STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		n.c	01	COMPL	ETED
		155386	A. BUILDI B. WING	ING		05/25/2	011
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIEF	R			LIBERTY ST		
 LAURFL:	S OF DEKALB				R, IN46721		
		CTATEMENT OF DEPICIENCIES			.,		(3/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL	1	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
K0000	REGOLINGIT OF			1110			D.II.Z
Kooo							
	A Life Safety C	ode Recertification	K000	00	The Laurels of DeKalb wishe	es to	
	·	isure Survey was			have this submitted plan of		
		the Indiana State			correction stand as our writte	en	
	-				allegation of compliance.Preparation and	/or	
	Department of				execution of this plan does n		
	accordance wit	th 42 CFR 483.70(a).			constitute admission to, nor		
					agreement with, either the		
	Survey Date: 05/25/11				existence of or the scope an	d	
					severity of any of the cited	oot	
	Facility Number: 000574				deficiencies, or conclusions forth in the statement of	sei	
	Provider Number: 155386				deficiencies. This plan is		
	AIM Number:	100266430			prepared and/or executed to		
					ensure continuing compliand		
	Surveyor: Amy	/ Kelley, Life Safety			with regulatory requirements	i.	
	Code Specialis				Our date of compliance is 6/24/2011.		
					0/24/2011.		
	At this Life Saf	ety Code survey,					
		alb was found not in					
	-	th Requirements for					
	Participation in						
	Medicare/Medi						
	•	O(a), Life Safety					
		the 2000 edition of					
	the National Fi	re Protection					
	Association (N	FPA) 101, Life Safety					
	Code (LSC) and	d 410 IAC 16.2. The					
	orginal buildin	g consisting of the					
	100, 200 and 4	400 halls was					
	surveyed with Chapter 19, Existing						
	Health Care Oc	· · · · · · · · · · · · · · · · · · ·					
		1					
	This one story	facility was					
	Tills offe story	racinty was					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0R521

Facility ID:

000574

TITLE

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	01	COMPI	ETED
		155386	B. WIN			05/25/2	011
		<u> </u>	P. (111)		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF F	PROVIDER OR SUPPLIEF	₹			LIBERTY ST		
LAUREL	S OF DEKALB		BUTLER, IN46721				
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	determined to	be of Type V (000)					
	construction a	nd was fully					
	sprinklered. T	he facility has a fire					
	alarm system v	vith smoke					
	l '	the corridors and					
	areas open to the corridors. The						
	facility has a capacity of 101 and						
	1	of 91 at the time of					
		of 31 at the time of					
	this survey.						
	Quality Review by	Robert Booher, REHS, Life					
	` ' ' '	list-Medical Surveyor on					
	06/01/11.	inst interior surveyor on					
	The facility was	s found not in					
	compliance wit						
	•						
	aforementione	-					
		as evidenced by the					
	following:						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0R521 Facility ID: 000574 If continuation sheet

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 01	(X3) DATE S COMPL	
	155386	A. BUII B. WIN			05/25/2	011
PROVIDER OR SUPPLIER S OF DEKALB		p. wav	STREET A	LIBERTY ST R, IN46721		
SOF DEKALB SUMMARY ST (EACH DEFICIENCE REGULATORY OR IT Smoke barriers are least a one half ho accordance with 8 terminate at an atriprotected by fire-raglass panels and stwo separate compeach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7 19.1.6.4 Based on observinterview, the facensure 1 of 1 control o	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) e constructed to provide at our fire resistance rating in .3. Smoke barriers may rium wall. Windows are ated glazing or by wired steel frames. A minimum of partments are provided on are are not required in duct toke barriers in fully ducted and air conditioning 7.3, 19.3.7.5, 19.1.6.3, Evation and acility failed to eiling smoke aintained to provide a fire resistance 8.2 requires smoke e continuous from to an outside wall. Dractice was not in a area but could affect laundry staff. The servation with the and the arector on 50 p.m., there was hole in the ceiling	KO	520 W L	LIBERTY ST	rk to ne on I fire nce m in e I in	(XS) COMPLETION DATE 06/24/2011
the dryers in th This was ackno	nkler head above ne laundry room. wledged by the ssistant at the time					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE COMPI 05/25/2	LETED	
	PROVIDER OR SUPPLIER		520 W I	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST R, IN46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
K0046 SS=C	duration is provided 19.2.9.1. Based on observeiew, the facile of 1 emerger annually for at duration in accompanies an annually for a facility of the conducted on each of the facility operational for test. Written resinspections and by the owner for authority having deficient practice occupants.	g of at least 1½ houred in accordance with 7.9. Evation and record lity failed to ensure acy lights was tested least a 1 1/2 hour ordance with LSC. Periodic Testing of acting Equipment and test shall be every required demergency light an 1½ hour pment shall be fully the duration of the ecords of visual ditests shall be kept or inspection by the g jurisdiction. This ce could affect all	K0046	On 6/6/11 the Maintenanc Director completed a test facility's battery operated emergency light located a generator which lasted for hours. The test was succeand the light worked withor fault. The facility contains reported emergen lights. Continued complians the regulation will be monitogened by the Maintenance Direct through the facility's preversal the corrected at the time observation and trends with reported to the facility's mesafety Committee and Quantiness of the regulations of the regulations of the regulations.	t the 1 1/2 essful ut no other cy ce of tored for entive eriances le of ll be onthly ality ne le for	06/24/2011

PRINTED: 06/10/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155386	B. WING		05/25/2011
	PROVIDER OR SUPPLIER		520 V	T ADDRESS, CITY, STATE, ZIP CODE V LIBERTY ST LER, IN46721	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0050 SS=F	1:30 p.m., a batemergency light the generator. review with the 12:30 p.m., a vanual test regionerated emergiavailable for residual and the street operated emergiavailable for residual and the street operated emergiavailable for residual and the street of the street operated emergiavailable for residual and the street of th	at unexpected times under at least quarterly on each familiar with procedures and are part of established bility for planning and assigned only to s who are qualified to p. Where drills are an 9 PM and 6 AM a coded ay be used instead of 19.7.1.2 d review and acility failed to ls were conducted ch shift for 1 of the ed quarters. This ce could affect all	K0050	On 6/3/11 the facility held a shift fire drill at an unannoun time.No other fire drills were missing from the date of the Life Safety Inspection.The facility's Maintenance Directe ensure each required fire dricompleted on each shift at varying times each quarter.Continued compliance the timeliness of required fire drills will be monitored by the Director of Maintenance.	ced last or will ll is

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Event ID:

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	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
AND TEAU	or conduction	155386	A. BUILDING		05/25/2011
			B. WING	ADDRESS CITY STATE ZIR CORE	35.25.2511
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST	
LAUREL	S OF DEKALB		I	ER, IN46721	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
into	Based on review Fire Drill Report Administrator at Director on 05/p.m., there was shift fire drill for 2010. Based with the Admin Maintenance Directord review	w of the "Monthly t" with the and Maintenance /25/11 at 12:01 s no record of a first or the third quarter d on an interview histrator and firector at the time w, no other was available for		Variances will be corrected a time of observation and tren will be reported to the facility monthly Safety Committee a Quality Assurance Committees. The Administrat will monitor compliance with regulation.	at the ds //s and tor
K0056 SS=E	installed in accord. Standard for the Ir Systems, to provid portions of the buil properly maintaine 25, Standard for th Maintenance of W. Systems. It is fully reliable, adequate system. Required equipped with wat	vation and acility failed to	K0056	By 6/24/11 J.O. Mory, Inc. v move the sprinkler head in the 400 hall medication room an sprinkler head in the laundry	he and the

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Event ID:

M0R521 Facility ID:

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If continuation sheet

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l	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMP 05/25/2	LETED
	PROVIDER OR SUPPLIER	!! !	520 W	ADDRESS, CITY, STATE, ZIP COI LIBERTY ST R, IN46721	DE	
	SOF DEKALB SUMMARY S (EACH DEFICIENT REGULATORY OR Installed in the medication root sprinkler heads buffer room we inches from the 5–6.3.3 require pendant sprink installed at least the wall. This was not in a recould affect an the 400 hall me the laundry root Findings include Based on observation and the sprinkler head buffer room we inches from the sprinkler head buffer room we inches from the acknowledged Director at the observation.	ETATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 400 hall om and 1 of 1 s in the laundry ere at least four e wall. NFPA 13, es upright and eler heads shall be st four inches from deficient practice sident care area but d number of staff in edication room and om. de: Evations with the and the irector on 12:55 p.m. to 1;52 kler head in the 400 or room was located om the wall and the in the laundry as located two e wall. This was by the Maintenance	520 W	LIBERTY ST	nches o other ound to be ompliance e monitored rector. cted at the d trends facility's ittee and	(X5) COMPLETION DATE
	3.1-19(b)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386			(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMP 05/25/2	LETED
LAUREL	PROVIDER OR SUPPLIER S OF DEKALB		520 W I BUTLE	ADDRESS, CITY, STATE, ZIP CODE LIBERTY ST R, IN46721		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
K0067 SS=E	comply with the prare installed in accommanufacturer's sponsive properties of the properties of the return ail heating, ventilated conditioning doserving adjoining 90A, the Standal Installation of A and Ventilation 2–3.11.1 requishall not be used supply, return, system serving This deficient presidents, staff 100, 200 and 44. Findings include Based on obsertions of the presidents of the	ecifications. 19.5.2.1, 9.2, 2.2 Evation and acility failed to gress corridors used as a portion r plenum for ating and air actwork (HVAC) and areas. NFPA ard for the Air Conditioning Systems at res egress corridors ed as a portion of a or exhaust air adjoining areas. or actice affects all and visitors in the 400 hall.	K0067	The facility respectfully r waiver of K067. The Lift Waiver Request will be r by the State by 6/14/11.	e Safety	06/24/2011

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 01	COMPL	
THIND I LITTLY	or condection	155386	A. BUILDING		05/25/2	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2	
NAME OF I	PROVIDER OR SUPPLIER	8		LIBERTY ST		
LAUREL	S OF DEKALB			R, IN46721		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		100, 200 and 400				
	halls were usin					
		eturn air system.				
		terview at the time				
	· ·	, the Maintenance				
		med the return air				
	was exhausted	into the corridor				
		rooms. The facility				
	has modified th	he HVAC system so				
	activation of th	ie fire alarm shuts				
	off supply air fa	ans. Additionally,				
	duct work conr	nected to the supply				
	air fans was eq	uipped with duct				
	detectors locat	ed downstream of				
	the air filters.	When activated, the				
	duct detectors	shut off supply air				
	fans. Finally, s	ince the HVAC				
	ducts penetrate	ed the smoke				
	barrier walls, s	moke dampers				
	which close up	on activation of the				
	fire alarm syste	em have been				
	installed at the	smoke barrier				
	walls.					
	3.1-19(b)					
K0069	Cooking facilities	are protected in accordance				
SS=E	_	.2.6, NFPA 96				
-	Based on recor	d review and	K0069	By 6/24/11 Fire Protection,		06/24/2011
	interview, the f			will complete repairs on the		
		iplete range hood		facility's kitchen range hood extinguishing equipment to	ı tire	
		ing system was UL		ensure it is UL 300 approved.No		
		J = 1 = 1 = 1 = 1 = 1		other facility equipment was		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386	A. BUI	LDING	NSTRUCTION 01	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE LIBERTY ST R, IN46721	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	(LSC) 19.3.2.6 LSC 9.2.3 refer Standard for Ver and Fire Protect Cooking Opera 8-2.1 requires components, in manual pull state or electrical defectorical defectorical defectorical defectorical defectories actuators, and dampers shall in proper operation in an manufacturer's NFPA 96, 7-2.2 fire-extinguish comply with state comply with state Testing of Fire Systems for Protection Restaurant Cook deficient praction resident in the in the event of Findings include Based on review Administrator at Maintenance D 05/25/11 at 12	entilation Control tion of Commercial tions. NFPA 96, all actuation icluding remote ations, mechanical vices, detectors, fire-actuated be checked for on during the ccordance with the listed procedures. requires automatic ing systems shall andard UL 300, Fire Extinguishing otection of oking Areas. This ce could affect any main dining room an emergency. de: w with and the irector on 2:13 p.m. of the Inc. range hood			found to be out of compliand with this regulation. The facil Maintenance Director will er all necessary facility equipm UL 300 approved. Continued compliance of this regulation be monitored by the Directo Maintenance. Variances with corrected at the time of observation and trends will reported to the facility's mor Safety Committee and Qual Assurance Committees. The Administrator will monitor compliance with this regulat	ity's asure aent is an will ar of all be be be athly ity	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155386	B. WIN			05/25/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LIBERTY ST		
LAURELS	S OF DEKALB				R, IN46721		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	inspection repo	ort titled "Range					
	Hood Systems	Report", the range					
	hood fire extin	guishing equipment					
	was not UL 300	approved. This					
	was acknowled						
		irector at the time					
	of record review						
	or record reviet	vv .					
	2.1.10/b)						
	3.1-19(b)						
K0000							
	A Life Safety Code Recertification		K	0000	The Laurels of DeKalb wishe	s to	
		sure Survey was		, , , ,	have this submitted plan of correction stand as our written		
		· ·					
		he Indiana State			allegation of	,	
	Department of				compliance.Preparation and execution of this plan does n		
	accordance wit	h 42 CFR 483.70(a).			constitute admission to, nor	01	
					agreement with, either the		
	Survey Date: 0	5/25/11			existence of or the scope and	d b	
					severity of any of the cited		
	Facility Numbe	r: 000574			deficiencies, or conclusions	set	
	Provider Numb	er: 155386			forth in the statement of deficiencies. This plan is		
	AIM Number:				prepared and/or executed to		
					ensure continuing compliance	e l	
	Surveyor: Amy	Kelley, Life Safety			with regulatory requirements		
		• • • •			Our date of compliance is		
	Code Specialist	-			6/24/2011.		
	A. d						
		ety Code survey,					
		alb was found not in					
	compliance wit	h Requirements for					
	Participation in						
	Medicare/Medi	caid, 42 CFR					
	Subpart 483.70	O(a), Life Safety					
	•	•					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386			(X2) MUI A. BUILD B. WING	DING	O2	(X3) DATE S COMPL 05/25/2 (ETED
	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	the National Final Association (NI Code (LSC) and 2004 addition hall) and the Tisurveyed with the Health Care October This one story determined to construction as sprinklered. The larm system with the detection in in areas open to the facility has a call the survey. The facility was compliance with aforementioned to the story of the facility was compliance with aforementioned the story of the facility was compliance with aforementioned the story of the st	FPA) 101, Life Safety 1410 IAC 16.2. The of the B Wing (300 herapy Gym was Chapter 18, New cupancies. facility was be of Type V (000) hd was fully he facility has a fire with smoke the corridors and the corridors. The apacity of 101 and f 91 at the time of					
K0046 SS=C	duration is provide 18.2.9.1 Based on obse	g of at least 1½ hour ed in accordance with 7.9. Evation and record	K00)46	On 6/6/11 the Maintenance Director completed a test on	the	06/24/2011
	review, the lac	lity failed to ensure			facility's battery operated		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155386		A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/25/2011			
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	annually for at duration in acc 7.9. LSC 7.9.3 Emergency Light requires an anriconducted on 6 battery powere for not less that duration. Equipoperational for test. Written reinspections and by the owner for authority havin deficient practions occupants. Findings include Based on observations and by the owner for authority having deficient practions. Findings include Based on observations and the generator of 1:30 p.m., a batter generator of the generator of t	d emergency light on 1 ½ hour pment shall be fully the duration of the ecords of visual d tests shall be kept or inspection by the g jurisdiction. This ce could affect all de: exation with the on 05/25/11 at ottery operated of was observed at During record Administrator at written record of an arding the battery gency light was not			emergency light located at a generator which lasted for a hours. The test was success and the light worked without fault. The facility contains no battery operated emergency lights. Continued compliance the regulation will be monited by the Maintenance Director through the facility's prevent maintenance program. Varwill be corrected at the time observation and trends will reported to the facility's more Safety Committee and Quanch Assurance Committees. The Administrator is responsible the compliance of the regulations.	1/2 ssful t o other / e of ored r tive sances of be nthly ity for		

000574

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(x2) MULTIPLE CONSTRUCTION 02			(X3) DATE SURVEY COMPLETED	
THEFTERN	and Plan of Correction indextification number. 155386		A. BUILDING		05/25/2011		
100000			B. WING OS/25/2011 STREET ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER							
LAURELS OF DEKALB			520 W LIBERTY ST BUTLER, IN46721				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	Based on observation and record review, the facility failed to ensure 1 of 1 emergency lights was tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than 1½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants.		K	0046	On 6/6/11 the Maintenance Director completed a test on the facility's battery operated emergency light located at the generator which lasted for 1 1/2 hours. The test was successful and the light worked without fault. The facility contains no othe battery operated emergency lights. Continued compliance of the regulation will be monitored by the Maintenance Director through the facility's preventive maintenance program. Variance will be corrected at the time of		er
					observation and trends will lead reported to the facility's more Safety Committee and Qual Assurance Committees. The Administrator is responsible the compliance of the regular	ithly ity for	
	1:30 p.m., a ba emergency ligh the generator. review with the 12:30 p.m., a w annual test reg operated emerge	evation with the con 05/25/11 at attery operated at at a conserved an arding the battery gency light was not					
	available for re	view.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155386	(X2) MI A. BUII B. WIN	LDING	G COMP		ATE SURVEY MPLETED 25/2011	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721					
PREFIX (EACH	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE		
3.1–19(IS SS=F) Fire drills varying conduction is aware to routine. For conduction competent exercise is conducted announce audible all Based or interview ensure for quarterial last 4 conduction occupants. Findings Based or Fire Drill Administs Director p.m., the shift fire of 2010 with the Mainten	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3.1–19(b) Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Monthly Fire Drill Report" with the Administrator and Maintenance Director on 05/25/11 at 12:01 p.m., there was no record of a first shift fire drill for the third quarter of 2010. Based on an interview with the Administrator and Maintenance Director at the time of record review, no other		K	0050	On 6/3/11 the facility held a 1 shift fire drill at an unannound time. No other fire drills were missing from the date of the Life Safety Inspection. The facility's Maintenance Director ensure each required fire drill completed on each shift at varying times each quarter. Continued compliance the timeliness of required fire drills will be monitored by the Director of Maintenance. Variances will be corrected a time of observation and trend will be reported to the facility monthly Safety Committee at Quality Assurance Committees. The Administrate will monitor compliance with regulation.	ced last or will I is ee of t the ds sond	06/24/2011	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 02 B. WING		02	COMPI	LETED
155386		155386				05/25/2011	
NAME OF PROVIDER OR SUPPLIER LAURELS OF DEKALB			STREET ADDRESS, CITY, STATE, ZIP CODE 520 W LIBERTY ST BUTLER, IN46721				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		ATE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	conducted. 3.1–19(b) 3.1–51(c)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M0R521

Facility ID: 000574

If continuation sheet

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